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ABSTRACT

This report proposes a planning model for successful drug-free schools based on the idea that the problems of drug-abusing youth are not solely the responsibility of the school but are the responsibilities of both the schools and community institutions. It notes that the process of planning for drug-free schools will require the school to identify a team of committed and interested staff, and that strong district leadership, commitment, and support for the team process is a necessary foundation. It advocates school activities being integrated with community activities and school personnel being joined by representatives from the community, such as substance abuse treatment institutions; enforcement agencies; and social, political, and religious organizations. The five phases of the planning model discussed are: (1) needs assessment and planning the information base; (2) planning the implementation; (3) implementation of school programs; (4) evaluation of school programs; and (5) dissemination of school progress. This five-phase comprehensive planning model describes both the process and the content for a comprehensive prevention and intervention strategy for schools and communities. The report concludes that schools will benefit from the time invested in planning, needs identification, and goal setting which will result in programs appropriate for the school and community; and that ongoing evaluation and dissemination will ensure effective, targeted, and publicly supported programs to achieve drug-free schools. (ABL)

THE Northwest Regional Educational Laboratory

PROGRAM REPORT

Planning Model for Successful Drug-Free Schools

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October, 1987

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Planning Model For Successful Drug-Free Schools

Recent reports in the literature have identified both the uneven and the limited success of past efforts to stem drug and alcohol use in schools and communities (Schaps et. al., 1986; Barnes, 1984; Weisheit, 1983; Goodstadt, 1985; Pollich et. al., 1984). In almost all cases the lack of significant success can be attributed to an inadequate understanding of both a process and the content of a comprehensive planning and implementation model for alcohol and drug prevention and intervention in our schools and communities. Shortcomings can often be attributed to "quick fix" program installations that lack sound planning and preparation (Griffin, 1987). This paper will describe a comprehensive planning model that addresses both the process and content required to meet the goal of drug-free schools. The model, based on the knowledge gained from research, is a dynamic, interactive, and cyclical process of identifying the most cost-effective strategies for achieving the goal of drug-free schools.

Our planning model (Figure 1), taken from Fox and Forbing (1986, in press), indicates that the problems of drug-abusing youth are not solely the responsibility of the school; they are the responsibilities of the schools and community institutions--the family, support systems and enforcement systems. The process ofplanning for drug-free schools will require the school to identify a team of committed and interest staff--an administrator, teacher, counselor/nurse to support staff member. Strong district leadership, commitment, and support for the team process is a necessary foundation for a sustained school effort. School personnel should be joined by representatives from the community--we ca ' them community partners--who together will serve as the school team. The role of the school team is to ensure that school activities are appropriate and integrated with community activities. Schools are not equipped to carry on mass media campaigns or provide treatment to students and their families. Drug and alcohol treatment institutions, enforcement agencies, social, political and religiousorganizations, all can provide needed resources necessary to a successful school effort.

Figure 2 presents examples of these community partners. The schools are centrally and interactively portrayed within the community in our solution to student drug use. We believe that only when the community and the schools share ownership of the drug abuse problem, is it possible to impact alcohol and drug abuse. This diagram presents the supporting role of state agencies who together can develop coordinating policies and supply matching funds for a school-community effort. Finally, national organizations, media, and departments of the federal government support through identification of the national issues and concerns and providing leadership in their solution.

A COMPREHENSIVE MODEL FOR DRUG-FREE SCHOOLS (K-12)

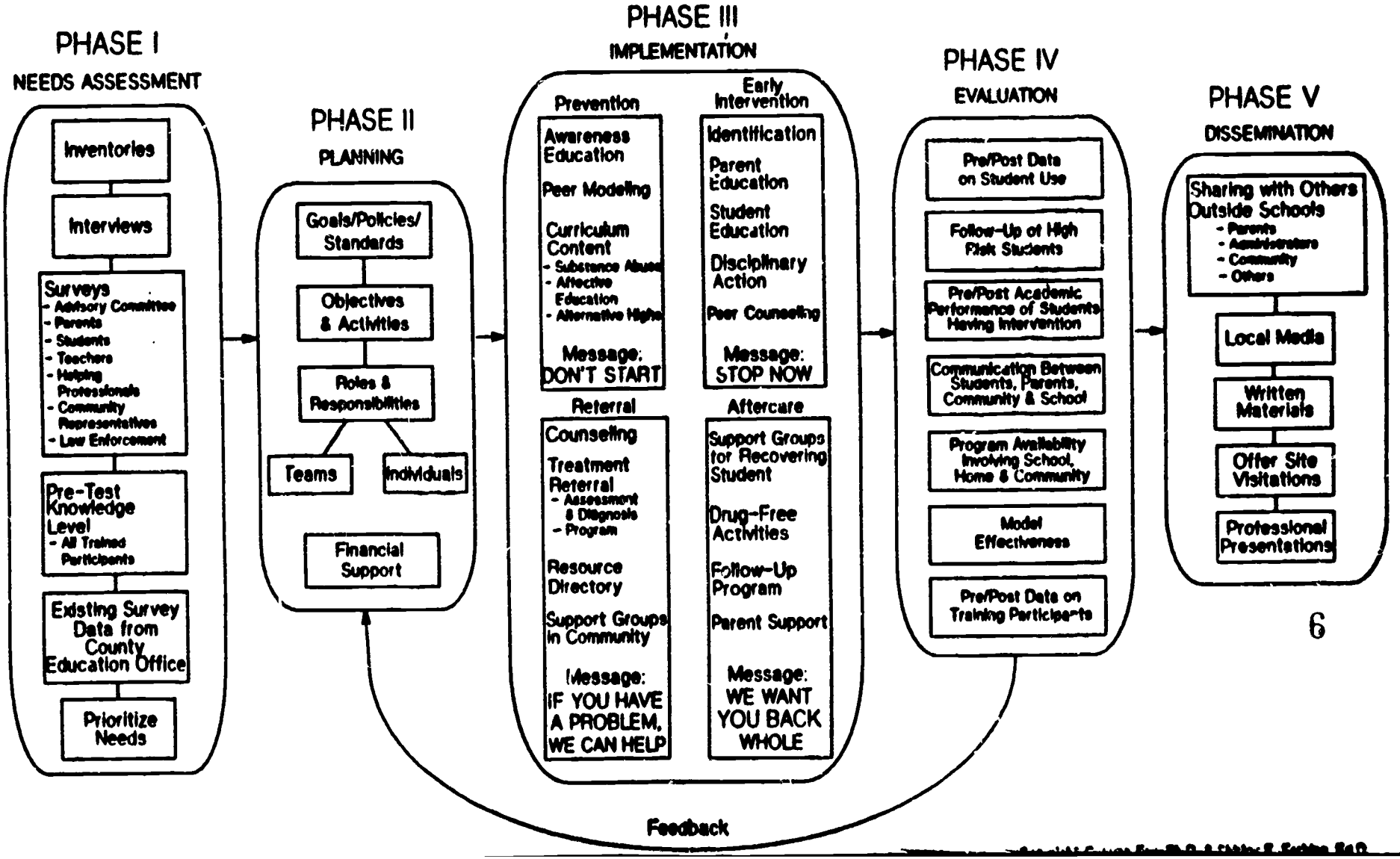
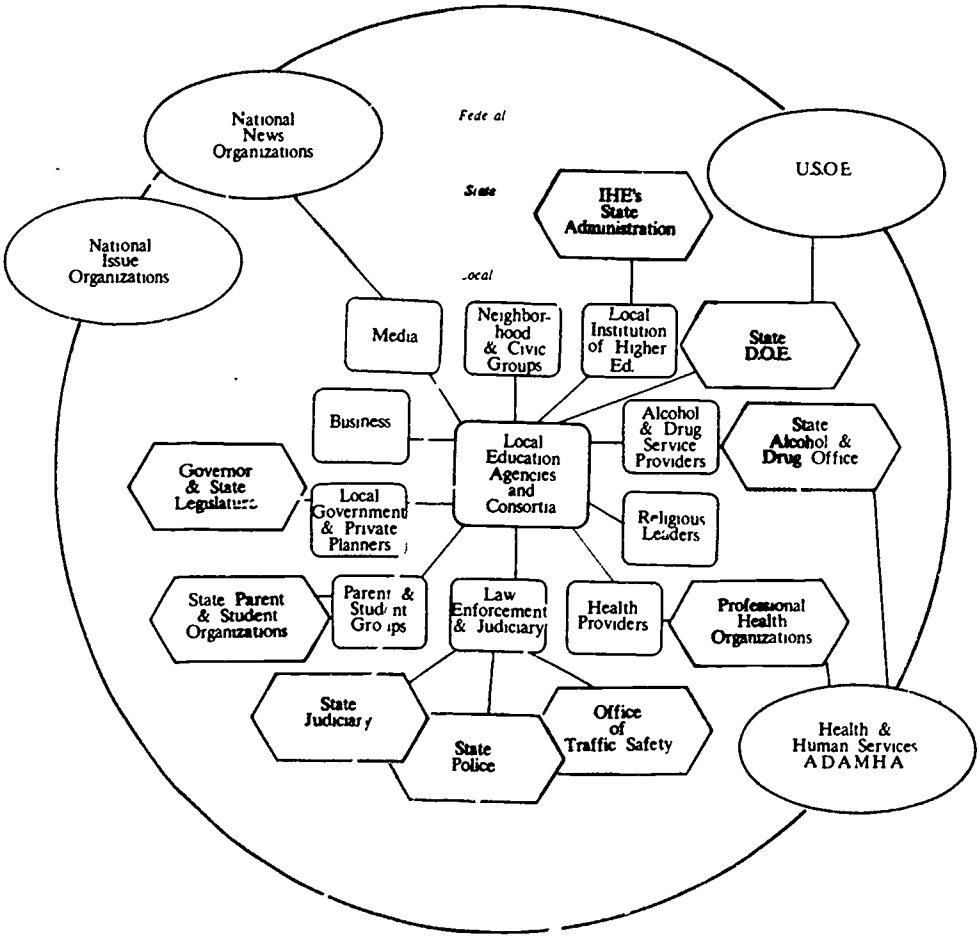


Figure 2

Key roles and relat'onships among
local, state, and national agencies



The planning model has five phases. Each can be described separately but the reader should not miss the fact that each interacts with the other phases. This is a comprehensive planning model. It is understood that communities may not implement all parts of each phase but each phase needs to be addressed for the planning process to work.

Phase I. NEEDS ASSESSMENT - Planning the information base

The purpose of the needs assessment is to identify the nature and scope of the alcohol and drug abuse problems in the schools. Local norms and social processes play a significant role in drug use by adolescents (Thompson et. al., 1976). Adopting successful policies, programs, or curricula from other locales does not necessarily ensure positive results. A curriculum appropriate for a white middle class culture is not necessarily appropriate for some Pacific Island cultures, for example. The needs assessment process brings a well-founded and thorough

understanding of the context of the school and community to considerations of program alternatives.

A combination of secondary and primary data collection methods can assist school and district teams in setting priorities and developing implementation strategies. Primary data collection methods usually consist of surveys and interviews. Surveys are among the most reliable and valid approaches to understanding the nature and magnitude of the substance abuse problem. With careful design and implementation it is possible to learn the extent of the problem and develop specific target areas of needs (e.g., age of first use, target drugs, attitudes).

Focus interviews with key informants offer an excellent source of information. Community leaders provide an understanding into the community norms and sanctions for use and/or abuse by teens. Teens themselves and school personnel can offer developmental or school related factors associated with use.

Secondary methods usually consist of assembling existing data on student behaviors such as absenteeism, drop-outs, disciplinary referrals, teacher requests for transfer, youth-involved vehicular accidents and deaths, overdose hospital admissions, per capita consumption of alcoholic beverages, arrests for drug related activities and reported child abuse. Looking at these data over time and comparing them to other communities, is helpful for analysis of the extent of the problem. Another source of indirect information is to inventory community resources--describe "who is doing what for whom" in the community.

The final step in the needs assessment process is to summarize the data in the form of problem statements. The school team and community partners identify which problems should be addressed by the community and which by the school. Finally, the team prioritizes the problem statements and begins to work together to address the highest priority problem areas.

The needs assessment process is not an initial task which, when completed, fixes all subsequent activities. Rather, it is an ongoing communication and feedback loop which should be reviewed at least annually by the school or district team.

Phase II PLANNING the implementation

Through systematic planning, the school or district team sets clearly defined goals and objectives for the(ir) school(s) and community groups. A goal is a statement of purpose that emanates directly from the problem statements formulated through the needs assessment. Long term goals may be ordered by their importance, while short term goals may be ordered by their feasibility. For example, if it is viewed as most essential to meet the pressing needs of dysfunctional students, then the short term goal of implementing a student identification and referral system for the few affected students may take some precedence over the development of a comprehensive prevention curriculum program to meet the long-term goal of drug-free schools.

Goals set by the school become the policies of the school district. If it is the goal of the school district to develop a comprehensive curriculum, then it is the policy of that district in its implementation. It is desirable that the school board establish a broad emphasis on alcohol and drug prevention and intervention coupled with specific discipline codes that clearly indicate that sale or use of alcohol or drugs will not be tolerated. School teams and curriculum committees will develop the implementation plans and strategies.

Once goals are established, the committee needs to become acquainted with state-of-the-art models of program delivery. "Reinventing the wheel" by each school team is not a prudent nor productive use of time. Recent research is unequivocal on those programs and practices that do not work and at least optimistic on the those that do (Schaps et. al., 1986; Thompson et. al., 1976).

Objectives are statements of what is to be done, how it will be accomplished, and when it will be accomplished. Generally, objectives are established annually and reflect the short-term goals. Activities are the means to achieve the objectives and the goals. These are the specific working steps.

A long-term commitment of school, district, and community resources is necessary for success of any prevention and intervention strategy. This commitment will strengthen, we believe, as the program proceeds and succeeds. We recognize that full commitment is not necessary nor expected at the outset (Armstrong et. al., 1986). The committee must consider both financial limitations and opportunities. Schools may draw on federal and state alcohol and drug abuse monies, supportive training from groups such as state and local traffic safety offices, law enforcement groups, private and public treatment facilities, and private sources such as that offered by Lions, Elks, and community foundations.

Assignment of roles and responsibilities is the final step of planning for implementation. School teams will identify the appropriate administrative and program development assignments while continuing to plan and monitor implementation. For example, administrator's can direct the school's curriculum review committee to review the proposed drug curriculum, teachers can begin training their colleagues in the program activities, and community partners may fund a media campaign urging parents to support drug-free activities.

Phase III IMPLEMENTATION of school programs

The activities selected for each school will be based on the goals and objectives selected in phase II. The school or district team may have to choose from among the four areas of a comprehensive program as a point of first priority: (1) prevention; (2) early intervention with users in the experimental or early user stage; (3) referral to treatment for those who are preoccupied with or have dependency on chemical substances; and (4) aftercare for those who have received treatment and are reentering the school setting. All aspects of the comprehensive program, however, are necessary to attain the goal of drug-free schools.

PREVENTION programs carry the message: Don't Start. Often, prevention is an afterthought--getting attention only if resources are available. As one of our state health educator's so aptly put it: "we deal only with those falling off the cliff while the thundering hoards are reaching the precipice." While the late 70s and early 80s brought great strides in treatment through support of third-party payments, the numbers of adolescents requiring treatment did not decline. As in all other areas of health policy, it is better to prevent the disease than to treat it.

Awareness education is an essential component of any prevention program. While some teachers will be more effective in teaching alcohol and drug prevention subject matter and should receive special training, all teachers and school personnel must be trained in the causes, symptoms, and effects of alcohol and drug abuse and in the recent findings of substance abuse research. At a minimum, awareness should include knowledge of:

- o the various drugs and their effects
- o the stages of use and observable symptoms
- o the relationship of abuse to other social and educational problems
- o how bio-chemical and socio-psychological factors are associated with dependency
- o legal implications of use
- o community resources.

Parent education is another vital tool in the prevention of alcohol and drug abuse. Parents need to be aware of the real dangers of student alcohol and drugs use and be able to communicate effectively with their children. In addition to drug and alcohol abuse awareness education, topics for parent education and support groups include:

- o normal and deviant child and adolescent behavior
- o communication skills at each age level
- o constructive discipline

Implementation of a comprehensive curriculum is the next feature of a school prevention program Research has amply demonstrated the need for an every-grade level, age-appropriate health curriculum armed with activities to ensure sufficient time-on-task to effect results (Abt, 1985; Weisheit, 1983; DiCicco et. al., 1984). Starting with the primary grades and moving through to seniors is recommended. Younger children should be especially targeted because they respect their school's teaching and are already "anti-drug." Implementing such a comprehensive curriculum requires that at every grade level it be based on sound theory and include extensive in-service training (Barnes, 1984; Schaps et.al., 1986).

A comprehensive curriculum approach must include curriculum content in the three domains: cognitive or knowledge, attitudes or affective skills, and behavior (Thompson et. al., 1976; Botvin, 1985). Goodstadt (1985, p 103) offers further general guidance for school

districts. He suggests that alcohol education programs are most effective when:

- o it is planned according to clearly defined objectives and time-frames, based on sound analysis of the alcohol problem
- o it is planned to include educational processes appropriate for the achievement of objectives, based on sound theoretical principals of influence
- o it takes into account both the positive and negative forces in the broader community
- o it incorporates carefully designed evaluation based on sound research principals

Essential elements are early curriculum include coping skills, peer pressure--recognizing and resisting it, self esteem and assertion skills, and problem-solving skills. Curriculum for later grades should extend these skills and include an understanding of the short-term effects and consequences of use, why teens use, attitudes toward use and users, and factors associated with dependency.

Within a comprehensive program, there are several program components which have been shown to be effective. Peer modeling programs are effective ways to prevent substance abuse. These programs include peer and particularly cross-age counseling, peer and cross-age tutoring and use of peers in teaching (Johnson, 1983). Community partners can help identify ways to support prevention programs, such as developing alternative recreation programs or conducting mass media campaigns.

The message of the Early Intervention phase is STOP NOW. Early intervention involves identification of students who are in danger of dependency or already dependent on alcohol or drugs. Identification of these youth will require the school professionals (counselor, teacher, or nurse) to be familiar with intervention techniques. Youth may be identified as being at-risk for breaking the school rules or merely because they are in a "risk" group such as children of alcoholics, single parent households, or members of gangs. The focus to identify the seriousness of the observed behaviors and potential for deeper involvement and take appropriate action.

Many of those identified for breaking specific alcohol or drug rules are referred to either separate or joint parent or student education groups. These programs may be run by the schools or community agencies (e.g., Alcohol Information Schools). Students are reminded of the school policy and for first infractions are given opportunities for remediation in lieu of punishment.

Peer counseling is also an effective intervention technique (Klepp, Halper and Perry, 1986). Many times it is the former users who are the most skillful at identifying users and their denial among their peers.

The community and school team members will identify complementary community activities as intervention strategies. These could include support groups for those accused of

child abuse or support groups for adult members of an alcoholic home.

The message of Referral services is IF YOU HAVE A PROBLEM, WE CAN HELP. Following intervention, if troubling behavior continues, the student and his parents are referred to an appropriate community agency for an assessment. Assessment and diagnosis for treatment are usually the function of the community agencies. Occasionally, a school may contract with a treatment agency for assessment services. Treatment is best offered by certified adolescent counselors in treatment agencies in the community.

School responsibilities for referral include maintaining an up-to-date resource directory of community assessment and treatment agencies. Community partners should assist in identifying, evaluating, and supporting treatment options in the community.

Student support groups, often within the schools themselves, offer continued peer coaching and support until treatment is initiated. Recovering students are excellent resources to those who have been referred for treatment.

The message of Aftercare is WE WANT YOU BACK WHOLE. Student support groups are an essential feature of the aftercare program. Students need to be reminded that they are important and not forgotten as they reenter the school following treatment. Students will be expected to follow the follow-up program of their treatment agency or complete other tasks designed to monitor and enhance treatment effectiveness. School counselors need to communicate with the treatment facilities for best results.

Drug-free activities are part of aftercare but they can be part of the entire school program, as well. Students need the opportunity to make new friends and enjoy a good time without the influence of chemicals.

Community partners can identify parent support groups which are available to parents with students in treatment or having been in treatment.

Phase IV EVALUATION of school programs

The problems of drug and alcohol abuse in our schools are enormous and the costs for making the wrong programmatic decisions are great. Each school team with its community partners must ensure that their planning and program implementation efforts are evaluated. An ongoing system of feedback and refinement or renewal of program activities is an essential component of success (Armstrong et. al., 1986; Hord and Loucks, 1980). Formative or process evaluation could identify: milestones of the planning progress, model program implementation and costs, numbers served, teacher reports of implementation problems and solutions, time spent engaging students, and informal reports of student responses to school based programs.

Summative evaluations include student outcomes such as pre and post tests of knowledge,

attitudes, use, and behaviors of both students and trainers, and follow-up studies of high-risk, referred, and treated students. More general school-level outcomes may be evidenced in fewer disciplinary referrals, suspensions, reports of violence and vandalism on school grounds, and overall school climate.

Ongoing formative and summative evaluations help identify needed resources, both financial and technical, staffing or program adjustments and adjustments in school-community relationships. Evaluation serves as a self-correcting mechanism to support ongoing program planning--setting goals, objectives, and activities.

Phase V DISSEMINATION of school progress

Dissemination assures that the good progress made by the schools and communities in achieving drug-free schools can be shared with other school districts. School administrators, parents, and community groups need to know of programs which have succeeded and failed to assist their planning efforts. Local media should be informed of effective school activities.

Successful programs need to be documented with a written description including their needs assessment process, policies, program goals and objectives, implementation activities, and evaluation methods. Exemplary programs could showcase their program by offering site visits to neighboring school teams and presenting their activities and evaluation results to local, state and regional groups.

CONCLUSION

This five phase comprehensive planning model describes both the process and the content for a comprehensive prevention and intervention strategy for schools and communities. Schools will benefit from the time invested in planning, needs identification and goal setting that will result in a well-phased implementation of programs appropriate to the school and community. Ongoing evaluation and dissemination will ensure effective, targeted, and publicly supported programs to achieve drug-free schools.

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